PRINTED: 08/27/2012 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-0391
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFIC		IDENTIFICATION NUMBER:	01		01	COMPLETED	
155135		A. BUILDING B. WING			07/27/2012		
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹			CLINIC DR		
\//EQT\/II	EW NITIDGING AND	REHABILITATION CENTER			ORD, IN 47421		
WESTVII	EW NORSING AND	REHABILITATION CENTER		BEDIC	JRD, IN 47421		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX					(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG					DEFICIENCY)		DATE
K0000							
	A Quality Assu	ranca Walle thru	K00	000	What corrective action(s) wil	ı	
	A Quality Assurance Walk-thru Survey was conducted by the Indiana State Department of				be accomplished for those residents found to have been affected by the deficient		
	Health.				practice.		
	Survey Date: 07/27/12  Facility Number: 000060				Inspection of the newly installed		
					10-year lithium battery smoke	-	
					detectors had been completed,		
					but not notated on a clearly identifiable checklist that could be		
	Provider Number: 155135			readily identified during th		ı be	
	AIM Number: 100266600					ns	
			ha or pl		have been identified and included on a clearly identified checklist, plus subsequent monthly		
	Surveyor: Steve Corya, Life Safety						
	Code Specialist/ICF-IID Surveyor						
	Supervisor			inspections.			
	Jupervisor						
	At this Quality Assurance		How will you identify oth		How will you identify other		
	Walk-thru survey, Westview Nursing and Rehabilitation Center was found not in compliance with 410 IAC 16.2-3.1-19(ff).  This one story facility was determined to be of Type V (000) construction and was fully				residents having the potential to be affected by the same deficient practice and what		
					corrective action will be taken.		
					This finding was found to poss	sibly	
					affect all residents.		
					NAME of the property of the proof in the		
					What measures will be put into place or what systemic		
		•			changes you will make to		
	sprinklered. The facility has a fire alarm system with smoke				ensure that the deficient		
	1				practice does not recur.		
	detection in the corridors and spaces open to the corridors with battery operated smoke detectors				,		
					The clearly identifiable checklist has been implemented and is in		
	in 43 resident	rooms and hard			use.		
	wired smoke d	etectors in 14					
	l		1		How the corrective action(s)		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000060

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	OF CORRECTION IDENTIFICATION NUMBER:  155135	(X2) MULTIPLE CC A. BUILDING B. WING	01	COMPLETED 07/27/2012
WESTVII	PROVIDER OR SUPPLIER  EW NURSING AND REHABILITATION CENTER	STREET A 1510 C BEDFO	ADDRESS, CITY, STATE, ZIP CODE LINIC DR DRD, IN 47421	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
			will be monitored to ensure deficient practice will not re i.e., what quality assurance program will be put into pla. The Maintenance Supervisor reviewed to ensure the prope and clearly identifiable check being used and will continue review this monthly for scheduse. This review has been a to the monthly maintenance schedule.  Compliance date: July 27, 2	the ecur,  ce.  has er list is to luled dded

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: BS0821

Facility ID: 000060

If continuation sheet

Page 2 of 4

PRINTED: 08/27/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A DIHI DING 01		COMPL	ETED	
		155135	A. BUILDING			07/27/2012	
			B. WIN		ADDRESS CHEV STATE JID CODE		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
					LINIC DR		
WESTVIEW NURSING AND REHABILITATION CENTER				BEDFORD, IN 47421			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			DATE
K9999							
	State Findings		K99	99	What corrective action(s) will		07/27/2012
	State 1 mamgs				be accomplished for those residents found to have been affected by the deficient		
	2.1.10 ENTUDO	AIM (ENTE AND					
	3.1-19 ENVIRO						
	PHYSICAL STA	ANDARDS			practice. Inspection of the new	practice. Inspection of the newly	
					installed 10-year lithium battery smoke detectors had been		
	3.1-19(a) The facility must be designed,						
	constructed and i	maintained to protect the			completed, but not notated on a		
	health and safety of residents, personnel				clearly identifiable checklist that		
	-			could be readily identified durir the related visit. Those inspections have been identified and included on a clearly identified checklist, plus		ng	
	and the public.					- al	
						ea	
	This State Rule has not been met as						
	evidenced by:				subsequent monthly inspection	ns	
	Based on interview and record review, the				How will you identify other		
	facility did not have documentation of a				residents having the potentia	al	
	system for maintaining the batteries in the			to be affected by the same			
				deficient practice and what			
	battery powered smoke detectors in 43 of			corrective action will be taken.		n.	
	43 resident rooms. This deficient practice			This finding was found to possibly		ibly	
	could affect all the residents.				affect all residents. What		
	Findings include:  Interview with the facility maintenance person at 2:45 p.m. on 07/27/12 indicated, "We didn't document the monthly checks				measures will be put into pla	ce	
					or what systemic changes yo	ou	
					will make to ensure that the		
					deficient practice does not		
					recur. The clearly identifiable		
					checklist has been implemente	ed	
					and is in use. How the		
	of the battery ope	erated smoke detectors.			corrective action(s) will be		
	There should be	two months worth. The			monitored to ensure the		
	smoke detectors were installed in April of				deficient practice will not recur,		
	2012." A review of the facility				i.e., what quality assurance program will be put into place.		
	maintenance records did not produce documentation of a checklist for the battery operated smoke detectors.				The Maintenance Supervisor h		
					reviewed to ensure the proper and clearly identifiable checklist is		
					being used and will continue to		
					review this monthly for scheduled		

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Event ID: BS0821

Facility ID: 000060

If continuation sheet Page 3 of 4

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/27/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:  155135	A. BUILDING  B. WING	01	COMPLETED 07/27/2012		
NAME OF PROVIDER OR SUPPLIER WESTVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1510 CLINIC DR BEDFORD, IN 47421				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)			
IAU	3.1-19(a)	LOC IDENTIFY TING INTONIVATION)	IAU	use. This review has been ad to the monthly maintenance schedule. Compliance date: July 27, 2012			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: BS0821

Facility ID: 000060

If continuation sheet

Page 4 of 4